City of Chandler

Employee Benefits Plan

(Restatement effective as of January 1, 2014)

Contents

Article 1. Introduction

1.1 Restatement and Purpose of the Plan

The City of Chandler (the "City") hereby amends and restates the City of Chandler Employee Benefits Plan (the "Plan"), effective as of January 1, 2014, unless a different effective date is herein explicitly stated. Except as specifically provided in this restatement, this restated Plan includes and supersedes all prior Plan documents, amendments and restatements.

The City has established the Chandler Health Care Benefits Trust, consistent with the provisions of Code Section 115 and other applicable laws, to provide a source of funding for benefits under the Plan.

1.2 Purpose of Restated Plan

The purposes of this restated Plan are:

(a) To provide Eligible Employees with health, life, disability and related benefits;

(b) To reflect the Employers' intent that the Plan operates as a health and welfare plan pursuant to all applicable sections of the Code and the Public Health Services Act;

(c) To supersede and replace any prior versions of the Plan;

(d) To clarify and incorporate spousal eligibility; and

(e) To bring the Plan into formal compliance with recent statutory and regulatory changes in the requirements for health and welfare plans and to reflect certain clarifying and required changes pursuant to final governmental regulations and rulings.

1.3 Applicability of the Plan

Except as otherwise provided, the provisions of this amended and restated Plan are effective as of January 1, 2014, and are applicable only to Employees in the employ of the City on or after January 1, 2014, Retirees covered on or after that date, and certain individuals electing COBRA continuation coverage.

1.4 Effect of Appendix

This Plan document is supplemented by an Appendix that provides additional information and, in some cases, overrides general Plan provisions. In the event of a conflict between a Plan provision and a provision in the Appendix, the provision in the Appendix shall govern with respect to the Employees or circumstances specified in the Appendix, and the Plan provision shall continue to govern with respect to other Employees or circumstances. The Appendix is, by this reference, incorporated into and becomes a part of this Plan.

Article 2. Definitions

2.1 Definitions

These definitions are in addition to the definitions of any other terms that appear elsewhere in the Plan. Whenever used in the Plan the following terms shall have the respective meanings set forth below unless otherwise required by the context in which they are used:

(a) **"Accidental Death and Dismemberment Plan"** means a plan of coverage that provides an indemnity benefit in the event of Participants' or Dependent's accidental death or dismemberment as identified in Appendix A.

(b) **"Actively At Work"** means an Employee who reports to his regular place of employment and performs the usual duties of his position. However, a Participant shall be considered to be Actively At Work on the last day preceding regular paid vacation, or on a regular non-working day, provided he was Actively At Work on the last preceding regular work day. Provided further, that in the case of any Health Plan which is subject to HIPAA, an Employee who is absent from work due to a health factor shall be treated as Actively at Work.

(c) **"Administrative Services Agreement"** means the written agreement and any attachments thereto, as amended, between the Plan Administrator and a service provider as needed to describe services to be provided by such provider.

(d) **"Alternate Recipient"** means any Child of a covered Employee who is recognized under a Qualified Medical Child Support Order as having a right of enrollment under this Plan as the covered Employee's Eligible Dependent.

(e) **"Annual Enrollment"** means the time period set aside each year for eligible Participants to change their elections under the Plan. Such election changes shall be effective as of the first day of the next following Plan Year and shall continue in effect throughout that entire Plan Year, except for a Change in Status or other allowable change in elections.

(f) **"Benefit Plan"** means any Accidental Death and Dismemberment Plan, Travel Accident Plan, Dental Plan, Employee Assistance Plan, Medical, Life Insurance Plan, Long-Term Disability Plan, Short-Term Disability Plan, or Vision Plan as set out in Appendix A (which is attached to this document and herein incorporated by reference). The terms of each Benefit Plan, as they may be set out in insurance contracts or other documents, shall form a part of this Plan in the same manner as if all the terms and provisions thereto were included herein. Terms of such Benefit Plans, including (as applicable) the amount payable, required Deductibles, Copayments, benefit maximums, conditions precedent to payment, limitations and exclusions, the procedures for coordinating benefits payable, the procedures for

naming beneficiaries and consequences for failure to name a beneficiary shall be as set forth in Appendix A.

(g) **"Change In Status"** means:

(1) Marriage, divorce, legal separation or annulment of the Employee;

(2) Death of the Employee's Spouse or Dependent;

(3) Birth, adoption or placement for adoption of a Child of the Employee;

(4) Termination or commencement of employment by the Employee, Spouse or Dependent, including a strike or lockout;

(5) A change in the employment status of the Employee, Spouse or Dependent with the consequences that such individual becomes or ceases to be eligible for benefits under a cafeteria plan or other employee benefit program.

(6) An election change made by a Spouse, former Spouse or Dependent under a cafeteria plan or other qualified benefits plan of such individual's employer, including an open enrollment election or a permissible change in status election under such plan;

(7) Commencement or return from an unpaid leave of absence by the Employee, Spouse or Dependent;

(8) Change in the place of residence or worksite of the Employee, Spouse or Dependent;

(9) An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to age, student status or similar circumstance.

(10) Enrollment by Employee, Spouse or Dependent in Medicare or Medicaid.

(h) **"Child/Children"** means:

(1) Only the following children:

(A) Biological children;

(B) Legally adopted children (or those placed for adoption with the Employee);

(C) Stepchildren;

(D) Foster children; or

(E) Children under the legal custody or legal guardianship of the Employee.

(2) In addition, the term Child shall include any child who is the subject of a valid Qualified Medical Child Support Order, as determined by the Plan Administrator.

(i) **"City"** means the City of Chandler, organized and existing under the laws of the State of Arizona.

(j) **"Claims Administrator**" means, with respect to any Benefit Plan, any individual or entity who is under a contract or agreement with the Plan Administrator to provide claim administration and related services.

(k) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), as amended, and the regulations issued thereunder.

(l) **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Each reference in this Plan to the Code or any provision thereof shall be deemed to include reference to any comparable or succeeding statutory provision that supplements or replaces the provision(s) of the Code to which such reference is made.

(m) **"Copayment"** means a percentage or amount of the cost of covered expenses for which each Covered Person is responsible.

(n) **"Covered Expense"** means a charge for a service or supply allowable under the applicable Benefit Plan.

(o) **"Covered Person"** means Eligible Employees, Qualified Retirees, Qualified Beneficiaries and Dependents who satisfy the requirements of coverage under the relevant Benefit Plan.

(p) **"Date of Hire"** means the first date on which an Employee is credited with an Hour of Service.

(q) **"Deductible"** means an amount of covered expenses for which each Covered Person is responsible before the Plan pays Benefits as specified in this Plan Document.

(r) **"Dental Plan"** means a plan providing dental benefits, as identified in Appendix A.

(s) **"Dependent"** means an Eligible Dependent who is properly enrolled for coverage under a Benefit Plan.

(t) **"Disability"** means a physical or mental condition that renders the Employee eligible for disability payments under the Social Security Act.

(u) **"Eligible Dependent"** means:

(1) The opposite-sex Spouse of an Employee who is not legally separated or divorced from the Employee.

(2) Each Child of an Employee who is less than 26 years old.

(3) Each Child of an Employee who is more than 26 years old, unmarried and primarily supported by the Employee and incapable of sustaining employment be reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the City within 31 days after the child ceases to qualify above. During the next two years, the City may, from time to time, require proof of the continuation of such condition and dependence. After that, the City may require proof no more than once per year.

(v) **"Eligible Employee"** means any of the following:

(1) A regular or initial probationary employee who works in a budgetarily approved position of 20 hours or more per week.

(2) A member of the City Council.

(w) **"Employee"** means any person employed and reported by the City as a common law employee. An individual is not an Employee if the City treats him or her as a non-Employee, even if a court or administrative agency determines that the person is a common law employee (including, for example, independent contractors, contract labor, consultants or advisors, leased employees, directors, and any person whose services are no paid for directly through the payroll department).

(x) **"Employee Assistance Program" (EAP)** means the employee assistance benefit program identified in Appendix A.

(y) **"Employer"** means the City.

(z) **"Group Health Plan"** means a group benefit plan, other than those provided under this Plan that provides medical coverage on an insured or uninsured basis. Group Health Plan includes, but is not limited to, any group, blanket, or franchise insurance, group practice or prepaid coverage plans, labor-management trusteed plans, union welfare plans, employer organization plans, group automobile insurance, individual automobile insurance based on the principles of "no fault" coverage, group coverage sponsored by or provided through a school, university or other educational institution, coverage under any governmental program, and coverage required or provided by law.

(aa) **"Health Plan"** means any health plans that are offered by the Employer. Such plans may include those providing medical, dental, vision, prescription drug, behavioral health care or similar benefits.

(bb) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder.

(cc) **"Insurer"** means an insurance company with a signed contract with the Plan Administrator to provide coverage under one or more of the Benefit Plans.

(dd) **"Insurance Policy"** means the written agreement, as amended, between the Plan Administrator and an Insurer which provides for insurance of one or more of the Benefit Plans. Any Insurance Policy shall be effective in accordance with the terms of such policy. Such insurance policies are set forth in Appendix A and are hereby made part of this Plan.

(ee) **"Life Insurance Plan"** means any plan of group-term life insurance (as described in Section 79 of the Code) or any other life insurance plan that may be offered by the Employer, as identified in Appendix A.

(ff) **"Long-Term Disability Plan"** means the plan providing long-term disability benefits to certain Eligible Employees, as identified in Appendix A.

(gg) **"Medical Plan"** means any plan providing medical benefits, as identified in Appendix A.

(hh) **"Participant"** means any Eligible Employee, Retiree or Qualified Beneficiary eligible to participate in the Plan according to the terms of the applicable summary plan description and who takes all steps necessary to enroll for, and maintain enrollment under the Plan.

(ii) **"Plan"** means the City of Chandler Employee Benefits Plan as set forth herein and as amended from time to time.

(jj) **"Plan Administrator**" means the person or persons responsible for the administration of the Plan, as set forth in Article 7.

(kk) **"Plan Sponsor"** means the City.

(ll) **"Plan Year"** means the period commencing each January 1 and ending the following December 31.

(mm) **"Prescription Drug Plan"** means the plan providing prescription drug benefits, as identified in Appendix A.

(nn) **"Public Health Services Act" or "PHSA"** means the federal Public Health Services Act, as amended from time to time. Each reference in this Plan to the PHSA or any provision thereof shall be deemed to include reference to any comparable or succeeding statutory provision that supplements or replaces the provision(s) of the PHSA to which such reference is made.

(oo) **"Qualified Beneficiary"** means any person afforded rights of continued medical coverage under COBRA as a result of a qualifying event, as defined in COBRA and in the Health Plan.

(pp) **"Qualified Medical Child Support Order" (QMCSO)** means a court or administrative order requiring the Plan to provide medical coverage to an eligible Child, as described in Section 3.7 of this Plan.

(qq) **"Qualified Retiree"** means an Employee who has retired from the City and who otherwise meets the criteria for participation in the Retiree Medical Plan.

(rr) **"Retiree Medical Plan"** means the program providing medical benefits to retirees, as set forth in Appendix A.

(ss) **"Short-Term Disability Plan"** means the plan providing short-term disability benefits to certain eligible Employees, as identified in Appendix A.

(tt) **"Spouse"** means the opposite sex person legally married to the Employee, Retiree or Qualified Beneficiary but shall not include an individual separated under a decree of legal separation.

(uu) **"Travel Accident Plan"** means the plan of coverage providing benefits to Employees in the event of an accident while the Employee is traveling on the Employer's business, as identified in Appendix A.

(vv) **"Trust"** means the Chandler Health Care Benefits Trust.

2.2 Gender and Number

Field Code Changed

Except when otherwise indicated by the context, any masculine or feminine terminology in this document shall also include the other gender, and the use of any term in the singular or plural shall also include the opposite number.

2.3 Requirement to Be in "Written Form"

Various notices provided by the City, and various elections made by a Participant are required to be in written form. Except as otherwise provided under applicable law, regulations or other guidance, these notices and elections may be conveyed through an electronic system.

Article 3. Eligibility, Participation and Coverage

3.1 Eligibility Provisions

(a) Employee Eligibility

A regular or initial probationary employee who works in a budgetarily approved position of 20 or more hours per week is eligible to participate in this Plan, subject to the terms of this Article 3.

A member of the City Council is eligible to participate in this Plan subject to the terms of this Article 3.

(b) Dependent Eligibility

Any Eligible Dependent of an Eligible Employee may be covered by this Plan if the Employee enrolls for Dependent coverage, subject to the provisions stated in this Article 3.

(c) Eligibility of Employees Married to Each Other

Eligible Employees of the opposite sex who are married to each other may both enroll as individuals, or one may enroll as an Eligible Dependent, but not both, and any Eligible Dependents may enroll as Dependents of one Employee or the other, but not both.

(d) Verification of Eligibility

The Claims Administrator or the Plan Administrator has the right to request information needed to determine an individual's eligibility for Benefits under this Plan.

(e) Notification

The Plan Administrator or its designated representative shall give all Eligible Employees reasonable notification of their eligibility to become Participants under the Plan and of the availability and terms of the Plan.

3.2 Enrollment Provisions

An Eligible Employee or Dependent shall become a Participant in the Plan by the Eligible Employee timely completing enrollment for himself and his Eligible Dependents and by paying any required Participant contributions.

An Eligible Employee, working 20 or more hours per week, will become eligible to enroll for coverage on the first day of the calendar month following 30 days of continuous employment.

An Eligible Employee who is an active member of the City Council shall become eligible to enroll for coverage on the first day of the calendar month following 30 days after the member is sworn in.

(a) If an active Eligible Employee enrolls himself and any Eligible Dependents for coverage within 31 days of his eligibility date, as specified above, coverage will become effective on the first day of the month following or coinciding with the date of enrollment.

(b) If an Eligible Employee acquires any Eligible Dependents by marriage, birth, adoption, or court order, he may enroll the Eligible Dependents for coverage within 31 days of the date of birth or acquisition; coverage will then become effective on the date of birth or acquisition.

(c) If an Eligible Employee or Eligible Dependent loses coverage under a state Child Health Insurance Program, Medicaid, or the qualification for a subsidy under a state Child Health Insurance Program, he may enroll himself and any Eligible Dependents within 60 days of such event. Coverage will become effective on the first day of the month following or coinciding with the date of enrollment.

(d) If an Eligible Employee does not enroll himself and/or his Eligible Dependents for coverage under this Plan at the times specified in the preceding sections, such persons will not be eligible to enroll for coverage until the next annual enrollment period.

This provision will be waived if there has been:

(1) A Change in Status event;

(2) An event deemed a HIPAA Special Enrollment Right under the terms and provisions of HIPAA; or

(3) A significant change in the coverage.

The Eligible Employee must apply for coverage for himself and/or his Eligible Dependents under this Plan within 31 days of such event. Coverage will then become effective on the first day of the month following or coinciding with the date of enrollment, except as may otherwise be required by law.

(e) Normally, if an Employee is not Actively At Work on the day coverage would otherwise begin, then coverage will begin on the day the Employee returns to active

work. However, if on the day the Employee's coverage is to begin the Employee is already on an FMLA leave of absence, he will be considered Actively at Work. Coverage for the Employee and any Eligible Dependents will begin in accordance with the terms of the Plan. Generally, an Employee is eligible to continue coverage under FMLA if:

(1) He has worked for his Employer for at least 12 months;

(2) He has worked at least 1,250 hours over the previous 12 consecutive months;

(3) During each of 20 or more calendar work weeks in the current or preceding calendar year, his Employer employs at least 50 people within 75 miles of his work site; and

(4) He continues to pay any required contributions for himself and any Eligible Dependents.

(f) Enrollment in a particular Benefit Option may be further limited by the terms of that option in accordance with Appendix A.

(g) If enrollment is not completed by the initial eligibility date,

(1) The Eligible Employee shall receive coverage for himself only under the Basic Life Insurance Plan, Employee Assistance Program, and the Travel Accident Plan, as provided under the terms of such Benefit Plans.

(2) For all other Benefit Plans, including supplemental or dependent Life Insurance Plan benefits, the Employee will not be eligible to participate except as provided in section 3.6 and upon properly enrolling.

3.3 Termination of Coverage

(a) For an Employee

An Employee's coverage under this Plan will terminate at the earliest of the following times:

(1) For any Employee who pays a contribution for the cost of the Plan, on the last day of the month for which a contribution was paid.

(2) For any Employee who ceases to be actively employed, on the last day of the month in which termination takes place.

(3) For any Employee who ceases to be actively employed for the required minimum number of hours, on the last day of the month in which the Employee ceases to be a regular full-time Employee or a regular part-time Employee.

(4) For any member of the City Council, the last day of the month in which they leave the Council.

(5) For an Employee covered by a collective bargaining agreement reached after good faith bargaining, the first day of any period during which such agreement does not provide for the application of this Plan to the Employees included in such collective bargaining unit.

(6) For any Employee whose coverage has been extended as specified in Section 3.8, 3.9 or 3.10, on the last day that the Employee is eligible for coverage.

(7) For any Employee whose coverage has been extended under COBRA, on the last day that the Employee is eligible for COBRA coverage.

(8) For any Employee who has been pensioned or retired (except for those Qualified Retirees who elect to continue coverage, as specified in Section 3.5), on the last day of the month following the date of retirement.

(9) On the date that this Plan is terminated.

(10) At the time of the Employee's death.

(b) For a Retiree

(1) A Retiree's coverage under the Retiree medical plan will terminate upon Medicare Entitlement (enrollment in Medicare).

(c) For a Dependent

A Dependent's coverage under this Plan will terminate at the earliest of the following times:

(1) At the earliest of any time listed in section (a) when coverage ceases for the covered Employee, provided however that subject to the terms of Appendix A, coverage may continue for the surviving Eligible Dependents in the event of the Employee's death.

(2) For any Dependent whose coverage has been extended under COBRA, on the last day that the Covered Person is eligible for COBRA coverage.

(3) The last day of the month in which a Dependent Child ceases to meet the definition of an Eligible Dependent.

(4) The last day of the month in which the Employee is relieved of a court-ordered obligation to furnish health care coverage for a Child.

(5) The last day of the month in which a covered Dependent Spouse is legally separated or divorced from the covered Employee, or their marriage is legally annulled or dissolved.

(6) At the time of the Dependent's death.

(7) Under the Retiree Medical Plan, upon the Retiree's Medicare Entitlement (enrollment in Medicare)

(d) Survivor Rights

(1) The City will extend medical, dental and vision coverage to the Spouse and eligible children of any employee killed in the line of duty in the course of their City employment. Except as required under state law, the medical, dental and vision coverage will be made available to the surviving Spouse and children at the cost that would normally be paid by the employee for the level of coverage elected. Eligibility for participation in the City's medical, dental and vision coverages will terminate upon the surviving Spouse's remarriage or attainment of Medicare eligibility or the surviving child's attainment of age 26.

3.4 COBRA Rights

Notwithstanding any provision to the contrary herein, nothing in this Article 3 shall affect the rights of a Qualified Beneficiary under COBRA.

3.5 Coverage

The provisions and requirements describing when and how Employees, Retirees, Qualified Beneficiaries and Dependents may become Covered Persons, the conditions and limitations as to coverage, and the circumstances under which coverage may terminate shall be as set forth in the applicable Benefit Plans.

3.6 Modifications to Coverage

Any changes as to the benefits and coverage of certain groups of Employees, Retirees and Qualified Beneficiaries shall be as set forth in the applicable Benefit Plans.

Periodically, Employees, Retirees and Qualified Beneficiaries may be given the opportunity to change their elections. Such open enrollment periods shall be conducted in accordance with the flexible benefits program sponsored by the City. In addition, Employees, Retirees and Qualified Beneficiaries may be given the right to change their benefit elections upon a qualified Change in Status.

3.7 Qualified Medical Child Support Orders (QMCSOs)

(a) If the Plan Administrator receives a court order and determines that it is a Qualified Medical Child Support Order (QMCSO), the Plan Administrator shall immediately

enroll for medical coverage under this Plan any Alternate Recipient who is the subject of such QMCSO if such individual is not already a Covered Person.

(b) QMCSOs shall only apply to Health Plans included in this Plan.

(c) Definitions applicable for this section:

(1) **"Alternate Recipient**" means any child of a covered Employee who is recognized under a QMCSO as having a right of enrollment under this Plan as the covered Employee's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as a covered Dependent, but for purposes of the reporting and disclosure requirements under PHSA, an Alternate Recipient shall be treated as a covered Employee.

(2) **"Medical Child Support Order" (MCSO)** means any judgment, decree or order (**including** approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction or administrative proceeding which:

(A) Provides for child support with respect to a covered Employee's Child or directs the covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or

(B) Enforces a law relating to medical child support described under the Social Security Act as it relates to Medical Child Support Orders.

(3) **"Qualified Medical Child Support Order" (QMCSO)** means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a covered Employee or covered Dependent is entitled under this Plan. A QMCSO must clearly specify the following:

(A) The names and last known mailing addresses of the covered Employee and each Alternate Recipient covered by the order;

(B) A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

(C) The period of coverage to which the order applies; and

(D) The name of the plan.

An order need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit or any option not otherwise provided to Covered Persons, except to the extent necessary to meet the requirements

of applicable state law relating to medical child support orders, as provided in Social Security Act Section 1908, as amended.

(d) Notice Procedures

Upon receipt of a QMCSO, the Plan Administrator shall, as soon as administratively possible:

(1) Send written notice to the covered Employee and each Alternate Recipient covered by the order (at the address included in the order) that the Plan Administrator has received such order and what the Plan's procedures are for determining whether the order qualifies as a QMCSO,

(2) Make an administrative determination whether the order is a QMCSO and notify the covered Employee and each affected Alternate Recipient of such determination.

3.8 Coverage During Family and Medical Leave

(a) A covered Employee who has been employed by the Employer for at least 12 months and who has at least 1,250 hours of Service with the Employer in the prior 12 consecutive months may take unpaid leave under the federal Family and Medical Leave Act (FMLA) for the following reasons:

(1) To care for the covered Employee's Child after birth, or placement for adoption or foster care;

(2) To care for the covered Employee's Spouse, son or daughter, or parent who has a serious health condition;

(3) For a serious health condition that makes the covered Employee unable to perform his or her job; or

(4) To care for an injured service person in accordance with the rules of FMLA.

Provided, however, that an otherwise eligible covered Employee shall not be entitled to leave under FMLA for reasons permitted under that law including, but not limited to, whether the Employee is considered a key employee who is not entitled to continue FMLA leave, or whether the Employee does not work in a location subject to FMLA because of the limited number of employees of the City within such region.

Rights granted under this Section 3.8 shall only apply to those covered Employees eligible for FMLA leave.

(b) A covered Employee who takes FMLA leave may continue to be a covered Employee under a Health Plan for the first 12 weeks of FMLA leave (26 weeks in the case of a leave described in section 3.8(a)(4)), provided he continues to pay the employee's share of the cost. Coverage under this Plan may end as of the last day of the month in which the Employee's FMLA leave ends. Coverage for a particular Benefit Plan may end sooner, as set out in Appendix A. A "qualifying event" under COBRA occurs when FMLA leave ends or, if earlier, when the employee informs the employer he does not plan to return to work when the leave would end. A qualifying event entitles the employee to COBRA coverage as provided in Article IV.

(c) From time to time, the Plan may make available coverage under any of its Benefit Plans to covered Employees who take FMLA. Such covered Employees may be required to make premium contributions toward such Benefit Plan coverage's. Premium contributions for covered Employees on FMLA leave may not exceed those required of active covered Employees.

(d) Employees returning to work immediately following FMLA leave shall be eligible to again participate in all available Benefit Plans in accordance with the terms of such Benefit Plans and the requirements of FMLA.

(e) The provisions of this Section 3.8 shall apply as set forth above, unless a state statute provides otherwise, in accordance with the rules of FMLA.

3.9 Coverage During Military Leave

Employees on Military Leave will continue to receive City (employer) paid benefits for medical, dental, and the employee assistance program. Employees must continue to pay for all the employee paid premiums (including premiums for dependent coverage, during this period of time).

(a) The covered Employee has the right to continue medical coverage for himself and covered Dependents at the employee contribution rate for up to 24 months of active duty.

(b) Upon completion of a military leave, a covered Employee who returns to work, regardless of whether they continued on the City's benefits during the leave, shall have the right to participate in all available Benefit Plans in accordance with the terms of such Benefit Plans and the requirements of USERRA.

Coverage under this Plan shall end as of the last day of the month in which the Employee's military leave ends. Coverage for a particular Benefit Plan may end sooner, as set out in Appendix A.

3.10 Coverage During Other Leaves

(a) Paid Leave. A covered Employee may continue coverage during any period of paid leave. Coverage for a particular Benefit Plan may end sooner, as set out in Appendix A.

(b) Leave Without Pay. A covered Employee ceases to be a Covered Person as of the last day of the month in which he leaves on a Special Leave without Pay. The employees benefit will continue at the employee contribution rate if the employee is paid for a minimum of 20 hours per week during the time of absence. Coverage for a particular Benefit Plan may end sooner, as set out in Appendix A.

3.11Reinstatement of Coverage

(a) Reinstatement of Coverage Following Lapse in Employee Contribution

Except as provided in subsection (b), notwithstanding any other provision in this Plan, any employee not subject to the COBRA provisions of Article 4, and who is eligible to participate in the Plan under the terms of Article 3, whose coverage ends solely because the required monthly contribution toward cost of the coverage has not been paid within 31 days following the due date established by the employer, the employee and any eligible dependents will be reinstated for coverage subject to the following conditions:

(1) Each employee and eligible dependent to be reinstated must submit a new enrollment form.

(2) Coverage will be reinstated on the date upon which the Plan approves the application for reinstatement, provided that all contributions due for coverage have been made on behalf of the employee to be reinstated; however, all reinstated participants will be subject to satisfaction of new deductible and coinsurance.

(b) COBRA participants

An Employee who has elected COBRA continuation of coverage will be considered to have had no lapse of coverage, provided that the coverage is in effect on the day before the Employee returns to eligible employment.

(c) After Termination of Employment

If an Employee terminates his employment with the Plan Sponsor, and is subsequently rehired by the Plan Sponsor, the Employee will be treated as a newly hired Employee.

Article 4. COBRA Continuation Coverage

4.1 Eligibility

Persons who are Covered Persons on the date immediately preceding a Qualifying Event, as defined in Section 4.3, and who lose Health Plan coverage because of that Qualifying Event are eligible for COBRA continuation coverage. Such individuals shall not be entitled to COBRA continuation coverage unless the initial required premium, as set forth in Section 4.8, is paid no later than 45 days after the date COBRA continuation coverage is elected. In addition, pursuant to HIPAA, an Employee's (or former Employee's) child born or adopted after the date of the Qualifying Event is eligible for COBRA continuation coverage.

4.2 Availability of Coverage

An Employee, Retiree, and/or Dependent eligible for COBRA continuation coverage may elect to purchase medical and/or dental benefits identical to those benefits which he or she was receiving under the Plan on the day before the Qualifying Event. If coverage provided to similarly situated individuals under the Plan is changed or eliminated, COBRA continuation coverage shall be changed or eliminated likewise. If coverage under a program is eliminated but the City continues to maintain one or more other group health plans, as defined in the Code, the Qualified Beneficiary shall have the right to elect to be covered under one of such other group health plans. No benefits provided under the Plan other than Health Plan benefits shall be available for continuation.

4.3 Qualifying Event

A **Qualifying Event** is one of the following, which, on occurrence, would result in loss of Plan coverage were it not for the right to purchase COBRA continuation coverage:

(a) For Employees:

(1) Termination of employment for reasons other than gross misconduct,

(2) Reduction in hours worked,

(3) The last day of leave under Family and Medical Leave Act (FMLA), or

(4) The day an Employee out on FMLA leave informs the Employer he does not intend to return to work.

(b) For Dependents:

(1) Ceasing to qualify as a Dependent under the Plan,

(2) An Employee's termination of employment for reasons other than gross misconduct,

(3) An Employee's reduction in hours worked, which results in loss of coverage,

(4) An Employee's death,

(5) Divorce or legal separation, and

(6) An Employee's or Retiree's entitlement to benefits under title XVIII of the Social Security Act (relating to Medicare).

A Qualifying Event occurs on the date of the Qualifying Event — not the date coverage ends because of the Qualifying Event.

4.4 Termination of COBRA Continuation Coverage

Field Code Changed

COBRA continuation coverage terminates on the earliest of the following:

(a) The date the Employer terminates all group health plans;

(b) For Employees and Dependents, 18 months from the Employee's termination or reduction in hours of employment;

(c) For Dependents, 36 months from a Qualifying Event defined in Section 4.03(B) other than the Employee's termination or reduction in hours of employment;

(d) For Retirees in situations in which the City files for bankruptcy, until the death of such Retiree, and for their surviving Dependents 36 months following the death of the Retiree;

(e) If a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled at the time of the Employee's termination or reduction in hours of employment, or pursuant to HIPAA, within 60 days thereafter, such Qualified Beneficiary and/or other family members who are also Qualified Beneficiaries shall be entitled to COBRA coverage for up to 29 months from the date of the Qualifying Event. Provided however, that this extension shall only be available if the Qualified Beneficiary notifies the Plan Administrator of this determination within 18 months of the Qualifying Event and within 60 days after the date on which the disabled individual is determined to be disabled by Social Security;

(f) The last day of the paid coverage period before the COBRA continuation coverage recipient fails to pay a required premium (other than the initial required premium) within 30 days of the due date;

(g) The date following the date of his election on which the COBRA continuation coverage recipient first becomes covered under another group health plan that does not limit or exclude his coverage because of a pre-existing condition; or

(h) The date following the date of his election on which the COBRA continuation coverage recipient becomes entitled to Medicare. The COBRA continuation coverage period for an Employee's Dependents who properly and timely elect and pay for COBRA continuation coverage does not terminate for up to 36 months from the earlier of:

(1) The date of the Qualifying Event, or

(2) The date the Employee becomes entitled to Medicare.

If a Qualifying Event defined in Section 4.3(b) occurs after a Qualifying Event defined in Section 4.3(a), an additional period of coverage is allowed for Qualified Beneficiaries who have elected and paid for COBRA continuation coverage properly and timely. However, the sum of the first and second periods of coverage cannot exceed 36 months from the date of the first Qualifying Event.

4.5 Notice Requirements

(a) The Employer must notify the Plan Administrator of a Qualifying Event in Subsections 4.3(a), 4.3(b)(2) through (4), and 4.3(b)(6) within 30 days of the date it occurs.

(b) The Employee or Dependent is responsible for notifying the Plan Administrator of a Qualifying Event in Subsections 4.3(b)(1) or 4.3(b)(5) within 60 days of the Qualifying Event or, if later, when coverage would be lost because of the Qualifying Event.

(c) The Plan Administrator must notify eligible persons of their COBRA continuation coverage rights within 14 days of the date it receives the notice under Subsections 4.5(a) or 4.5(b).

(d) An Employee or Dependent determined under Title II or Title XVI of the Social Security Act to be disabled within 60 days of the Employee's termination or reduction in hours of employment must notify the Plan Administrator of this determination within 60 days after the determination date and during the first 18 months of COBRA coverage. The Employee or Dependent must notify the Plan Administrator of any final Social Security determination that he is no longer disabled within 30 days of the determination.

4.6 Election Period

A person eligible for COBRA continuation coverage has 60 days from the date Plan coverage would otherwise end or, if later, the date the person is sent an election rights notice, to notify the Employer or the Plan Administrator of an election. Until the election period expires, an eligible person may change or revoke any election. Failure to elect COBRA

continuation coverage within the prescribed election period results in a waiver of the right to COBRA continuation coverage.

4.7 Election Rules

(a) Scope of Election

A person eligible for COBRA may elect to continue the same coverage he had prior to the Qualifying Event. In the case of an individual who was covered by both medical and dental on the day before the Qualifying Event, such person must elect to continue both of such coverages.

(1) Employee's Election

An Employee eligible for COBRA continuation coverage may elect to continue coverage for himself and his Dependents.

(2) Dependent's Election

(A) A Dependent Spouse eligible for COBRA continuation coverage may elect to continue coverage for himself and for his Dependent children.

(B) A Dependent child eligible for COBRA continuation coverage may elect to continue coverage for himself.

(b) After-Acquired Dependents

Employees and Dependents on COBRA continuation coverage may elect to cover Dependents acquired after their eligibility date, as described in Section 4.1, provided they notify the Employer or the Plan Administrator of their election in the manner and within the time set forth in Article 3. Newly acquired Dependents, other than those of an Employee or former Employee acquired by birth or adoption, do not have an independent right to elect COBRA continuation coverage as a Qualified Beneficiary. Failure to notify the Employer or the Plan Administrator within the prescribed time waives the right to add a newly acquired Dependent to COBRA continuation coverage.

4.8Required Premium

As a condition of receiving COBRA continuation coverage, eligible persons must agree, on forms supplied by the Employer or its designated administrator, to pay any required premiums to the Plan and must make required premium payments as requested. The Employer or its designated administrator will determine the required premium amount, which must not exceed one hundred and two percent (102%) of the applicable premium, or one hundred fifty percent (150%) during the disability extension period, nor be changed more frequently than permitted by law.

4.9 Right to Convert COBRA Continuation Coverage

An individual receiving COBRA continuation coverage shall have the right to convert such coverage to individual coverage as permitted under the applicable Administrative Services Agreement or Insurance Policy.

4.10 Conformance with COBRA

In the event any provision of this document, including the applicable Appendices, fails to comply with requirements of applicable law or fails to determine the right or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by this Plan be greater than those required to be provided by COBRA.

Article 5. Other Benefit Coverage

5.1 Benefit Limitations

Benefits provided under any Benefit Plan may be limited by benefits received by a Covered Person from other sources. Such sources may include benefits payable under Workers' Compensation, Social Security, Medicare or other government-sponsored programs. Such sources may also include benefits from other insurance policies, plans or programs, including those sponsored by a Covered Person's own employer.

5.2 Health Plan Coordination of Benefits

Benefits payable for Covered Expenses of a Covered Person who also is entitled to benefits from another Group Health Plan shall be coordinated so that the total amount payable shall not exceed the amount of the Covered Expense, as set forth in each Health Plan.

5.3Special Medicare Rules

Except as otherwise prohibited by federal law, any otherwise Covered Person who is also entitled to benefits under the Medicare program may elect or reject medical coverage under this Plan.

This Plan will pay benefits primary to Medicare only when required to do so by law. In all other instances, this Plan will pay secondary to Medicare. Whenever this Plan may lawfully assume a secondary position and the Covered Person becomes eligible for Medicare benefits, he shall be deemed to be covered by both Medicare parts A and B for all purposes under this Plan. Such Covered Person shall be considered to be covered by Medicare on the earliest date any coverage under Medicare could have been applicable to him had he applied for Medicare benefits in a timely manner.

5.4 Subrogation and Reimbursement

To the extent permitted by law, the Plan shall have the option of becoming subrogated to all claims, causes of action and other rights which the Covered Person (or his estate, parent or guardian) may have against a third party or insurer, government program, or other source of coverage for monetary damages, compensation or indemnification on account of any illness or injury allegedly caused by a third party.

(a) The Plan and the City shall have the following rights:

(1) To pursue a Covered Person's legal claims or rights against another party, or any insurance company, when plan benefits are paid or provided to a Covered Person and the condition, illness or injury for which the benefits were paid either were caused by the other party or are covered by other insurance.

(2) To pursue a Covered Person's legal rights against any other party or under any insurance coverage with respect to any injury, illness or condition for which this Plan has provided benefits.

(3) To be reimbursed from any damage award or insurance proceeds by the Covered Person and his legal representatives, estate and heirs for the full value of any benefits provided in relation to an injury, illness or other condition which is caused by the other party or is covered by other insurance.

(b) Subrogation applies whenever another person or insurance carrier is, or may be considered, liable for damages or pays insurance proceeds with respect to a Covered Person's injury, illness or condition, and this Plan has provided or paid benefits (or is legally required to pay) with respect to such injury, illness or condition.

By accepting coverage or benefits under the Plan, the Covered Person agrees that, to the extent of the full value of any such benefits paid or provided by the Plan, the Plan and the City are subrogated to all rights of the Covered Person against any third party or insurance company.

By accepting coverage or benefits under this Plan, the Covered Person:

(1) Agrees that the Plan and the City may assert their subrogation rights independent of the Covered Person.

(2) Agrees and is obligated to cooperate with the Plan and its agents to pursue and protect the Plan's and the City's subrogation rights. Among other things, the Covered Person shall provide the Plan with any relevant information requested and shall sign and deliver any documents requested by the Plan.

(3) Agrees that the Plan's and the City's rights of subrogation shall be considered as a first priority claim against any other person or entity, to be paid before any claims are paid, including claims by the Covered Person for general damages.

(4) Agrees that he will not release any party from liability for the payment of medical expenses without first obtaining the written consent of the Plan.

(5) Agrees that, if he enters into litigation or settlement negotiations regarding the obligations of or claims against other parties, he will notify the Plan and will not prejudice in any way the Plan's and the City's subrogation rights.

(6) Agrees that the Plan and/or the City or their agents may take any lawful action to pursue and protect the Plan's and the City's subrogation rights.

(7) Agrees that the costs of legal representation of the Plan and the City in matters related to subrogation shall be borne solely by the Plan and the City, and that

the costs of the Covered Person's legal representation shall be borne solely by the Covered Person, unless there is a written agreement to the contrary. That is, unless the Plan and the City agree otherwise in writing, the Plan's and the City's rights to recover the full value of benefits paid or provided to the Covered Person shall in no way be diminished by the cost of legal representation of the Covered Person.

(c) Reimbursement applies whenever a Covered Person recovers damages or insurance proceeds by settlement, verdict or otherwise for or in relation to an injury, illness or other condition and the Plan and/or the City has paid or provided benefits in relation to such injury, illness or other condition.

By accepting coverage or benefits under the Plan, the Covered Person:

(1) Agrees on behalf of himself and his legal representatives, estate and heirs, that the Plan and/or the City shall be reimbursed promptly from any settlement, verdict, insurance proceeds or other recovery, the full value of the benefits paid or provided by the Plan.

(2) Agrees that the Plan or the City, at their option, may collect amounts from the proceeds of any settlement, verdict, judgment, insurance coverage or other recovery by the Covered Person or his legal representative, regardless of whether the Covered Person has been fully compensated.

(3) Grants the Plan and the City a first priority lien, to the extent of the Plan's and the City's claim for reimbursement, against the proceeds of any such settlement, verdict, insurance proceeds or other recoveries or amounts received by or on behalf of the Covered Person or his legal representatives, estate or heirs.

(4) Assigns to the Plan and the City any benefits the Covered Person may have or be entitled to under any automobile policy or any other coverage, to the extent of the Plan's and the City's claim for reimbursement.

(5) Agrees to sign and deliver, at the request of the Plan, any documents that are needed to protect such lien or effect such assignment of benefits.

(6) Agrees to cooperate with the Plan and its agents, to provide any requested information, and to take such actions as the Plan or its agents request, all to protect the right of reimbursement of the Plan and the City and to assist the Plan and/or the City in making a full recovery of the value of the benefits paid or provided.

(7) Agrees to take no action that would prejudice the Plan's and the City's rights of reimbursement.

(8) Agrees that the Plan and the City shall be responsible only for those legal fees and expenses to which they agree in writing.

(9) Agrees to hold any proceeds of any settlement, verdict, judgment, insurance coverage or other recovery in trust for the benefit of the Plan and the City and that the Plan and the City shall be entitled to recover from the Covered Person reasonable attorney fees incurred in collecting such proceeds from the Covered Person.

5.5 Right to Receive and Release Information

For the purpose of enforcing or determining the applicability of the terms of this Article 5, or any similar provision of any other plan, the Plan Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes.

Article 6.Contributions and Funding

6.1 Funding of the Plan

The Trust shall be used to finance the benefits under the Plan. In some cases, insurance contracts will be purchased by the Trust to provide benefits.

The City may modify its funding of the Plan from time to time to accomplish the purposes of the Plan.

6.2 Source of Contributions

The City may require a Participant to pay any portion of the cost of the benefits provided by a Benefit Plan. Such contributions may or may not be made as part of a cafeteria plan as defined in Section 125 of the Code. Amounts payable by Participants may differ, depending on the type of coverage provided or other factors. Any remaining costs shall be borne by the Trust.

Article 7.Administration

7.1 Plan Administrator

The administration of the Plan shall be under the supervision of the City, as Plan Administrator. It shall be a principal duty of the City to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to benefits under the Plan.

7.2 Activities, Duties and Responsibilities of the Plan Administrator

(a) The City shall have the authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have such powers and duties as may be necessary or appropriate to discharge its functions, including, but not limited to, the discretionary authority to do the following:

(1) To establish a funding policy and method consistent with the objectives of the Plan.

(2) To construe and interpret the Plan and resolve all ambiguities thereunder, to receive certification by the Employer of any Employee's satisfaction of the eligibility requirements of the Plan, to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefit;

(3) To make a determination as to the right of any person to a benefit;

(4) To make and enforce such rules and proscribe the use of such forms as may be necessary or appropriate for administration of the Plan and to obtain from Employees such information as may be necessary or appropriate for the proper administration of the Plan and, when appropriate, to furnish such information promptly to any persons entitled thereto;

(5) To decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions. The Plan Administrator's interpretation in good faith shall be final and conclusive on all persons claiming benefits under the Plan;

(6) To prepare and distribute to Participants and Beneficiaries, in such manner as the City determines to be appropriate, information explaining the Plan;

(7) To keep such records and accounts as the Plan Administrator deems necessary to administer the Plan, using such books and methods of accounting as the Plan Administrator shall determine;

(8) To arrange for the payment of benefits and expenses;

(9) To prepare and file any reports or other documents required by the Code or PHSA;

(10) To engage an independent public accountant to conduct such examinations and to render such opinions as may be required by applicable law;

(11) To judge whether objective criteria specifically set forth in the Plan have been satisfied with respect to any applicable condition, limitation, and restriction or waiver thereof;

(12) To determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the City and any third party, as appropriate, of the amount of such benefits; to make claim decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part;

(13) To delegate to other persons any duty or administrative tasks that otherwise would be a responsibility of the Plan Administrator under the terms of the Plan;

(14) To provide for any required bonding of fiduciaries and other persons who may from time to time handle Plan assets;

(15) To make such administrative or technical procedures for the Plan as may be reasonably necessary or appropriate to carry out the intent of the City, including such procedures as may be required or appropriate to satisfy the requirements of the Code, PHSA or any other applicable law, regulation or governmental policy;

(16) To communicate to any Insurer or other supplier or administrator of benefits under this Plan all information required to carry out the provisions of the Plan; and

(17) To take all reasonable steps to correct any errors or omissions that may arise in the operation of the Plan.

(c) The City, the Plan Administrator and any person to whom a duty in connection with the administration, management or operation of the Plan is delegated, may utilize and rely on the services of agents and such clerical, legal, accounting and other means of assistance (including services of persons employed by or rendering services to the Employers) as it shall from time to time deem necessary or desirable. An opinion of legal counsel, independent public accountant or other expert or advisor, shall be full and complete authorization and protection with respect to any

action taken, omitted or suffered by the Plan Administrator or its delegee in good faith and in accordance with such opinion. Payment for such services or assistance may be made by the City.

(d) The Plan Administrator may from time to time establish rules and procedures for administration of the Plan not inconsistent with its provisions, and administer the Plan in accordance with its provisions and such rules and procedures. The Plan Administrator shall have the exclusive right to interpret the terms and provisions of the Plan and to resolve all questions arising thereunder, including without limitation the right to resolve and remedy ambiguities, inconsistencies or omissions in such Plan. The Plan Administrator shall endeavor to act in such a way as not to discriminate in favor of any class of Employees, Participants or other persons. All interpretations, determinations and decisions of the Plan Administrator in respect of any matter or question arising under the Plan shall be final, conclusive, and binding upon all persons, including without limitation Employees, Participants and any and all other persons having or claiming to have any interest in or under the Plan.

(e) The Plan shall be interpreted by the Plan Administrator in accordance with its terms and their intended meaning. If, due to errors in drafting, a provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations by the Plan Administrator or other evidence of intention, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent. The City shall amend the Plan retroactively to cure any such ambiguity. This subsection may not be invoked by a Participant, Beneficiary or any other person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Plan Administrator.

7.3 Data

All persons entitled to benefits from the Plan must furnish to the Plan Administrator such documents, evidence or information as the Plan Administrator considers necessary or appropriate for the purpose of administering the Plan, including information concerning marital status. It shall be an express condition of the Plan that each such person must furnish such information and sign such documents as the Plan Administrator may reasonably require before any benefits become payable from the Plan.

Article 8.Amendment and Termination

8.1 Right to Amend

The City reserves the right, in its sole discretion, at will and at any time and from time to time, but subject to requirements of law, to modify, amend or eliminate, in whole or in part, any or all provisions of the Plan, prospectively or retroactively, including but not limited to, any benefit, benefit structure, condition for or method of payment, or rate of contribution, whether applicable to all or a category of individuals.

8.2 Right to Terminate

The Plan is established with the intention of being maintained indefinitely. Notwithstanding, the City reserves the right, at will and at any time, but subject to requirements of law, to modify, suspend, interrupt, merge or terminate the Plan.

Article 9.Claim and Appeals Procedures

9.1 Claim and Appeals Procedures

Claims and appeals procedures and procedures shall be set forth in the terms of each Benefit Plan in Appendix A. Provided however, that should the terms of any Benefit Plan not comply with applicable claims rules of PHSA, the terms of such Benefit Plan shall be interpreted as consistent with the minimum requirements of PHSA.

Participants and beneficiaries should refer to the particular claims procedures for each Benefit Plan for more details.

Article 10.HIPAA

10.1 Permitted Disclosures of Protected Health Information

Unless otherwise permitted by law, and subject to obtaining written certification pursuant to Section 10.6, on and after April 14, 2003, a Participating Plan that is a Health Plan as defined in 45 CFR §160.103, (or a health insurance issuer with respect to such Health Plan) may disclose Protected Heath Information (as defined in 45 CFR §164.501) to the City solely for the purpose of enabling the City to perform administrative functions related to the treatment, payment and health care operations of such Health Plan as defined in 45 CFR §164.501.

In no event shall the City be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

10.2 Conditions of Disclosure

The City agrees that with respect to any Protected Health Information disclosed to it by a Health Plan (or a health insurance issuer with respect to the Plan) that it shall:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Health Plan or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from a Health Plan agree to the same restrictions and conditions that apply to the City with respect to Protected Health Information.

(c) Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the City.

(d) Report to a Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available Protected Health Information in accordance with 45 CFR §164.524.

(f) Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526.

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

(h) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from a Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with subpart E of 45 CFR §164.

(i) If feasible, return or destroy all Protected Health Information received from a Health Plan that the City still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Ensure that the adequate separation between a Health Plan and the City, required in 45 CFR §504(f)(2)(iii), is satisfied.

(k) Implement administrative, physical, and technical safeguards (including written policies and procedures) that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic Protected Health Information that it creates, receives, maintains, or transmits as required by the security rule of HIPAA.

10.3 Separation Between Health Plan and City

To satisfy the requirements of Section 10.2(j) above, the following conditions shall apply:

(a) Only the following employees, or classes of employees, or other persons under control of the City, shall be given access to the Protected Health Information to be disclosed:

Human Resources Director
Benefit Programs Manager
Employee Services & HRMS Manager
Employee Services & HRMS Analyst
Human Resources Manager
Human Resources Manager – Client Services
Benefits Analyst
Human Resources Analyst
Senior Human Resources Analyst
Human Resources Specialist
Human Resources Management Assistant
Human Resources Assistant
Human Resources Receptionist
City Attorney
Assistant City Attorney (Benefits & Employment)
Worker's Compensation Coordinator
Safety Coordinator
Training & Development Coordinator
Management Services Director
Accounting Manager

Accounting Supervisor
Accounting Specialist
Payroll Specialist
Senior Payroll Specialist
Budget & Research Analyst
Budget Manager
Senior Budget & Research Analyst
Systems Analyst
Financial Systems Supervisor
Admin Support II
CIO
EAM Func. Lead
Executive Assistant
IT Senior Sys Spec
IT App Specialist
IT App Specialist
IT App Sup Spec
IT Applications Specialist
IT Apps Support Manager
IT Comm. Coord
IT Coordinator
IT Database Analyst
IT Desktop Spec
IT Desktop Tech
IT GIS Coordinator
IT GIS Database Analyst
IT Infrastructure Manager
IT Messaging Analyst
IT Messg Dev
IT Network Analyst
IT Prin Sys Analyst
IT Prin Sys Spec (IT Senior Sys Spec)
IT Prin Systems Analyst (Oracle)
IT Principal Sys Specialist
IT Security Administrator
IT Security Analyst
IT Service Desk Supervisor
IT Services Manager
IT Senior DB Analyst (IT Senior Sys Spec)
IT Senior Project Mgr
IT Training Coord
IT Webmaster

IT Systems Specialist
Oper Sys Analyst
Senior Mgmt Asst
Senior Systems Analyst
Senior Systems Analyst (Oracle)
Systems Analyst
Systems Analyst (SQL DBA)
Senior Accountant-A/R
Accounting Specialist-Receipts
Senior Financial Analyst
Financial Analyst
Budget Management Assistant

(b) The access to and use of Protected Health Information by the individuals described in Section 10.3(a) above shall be restricted to the plan administration functions that the City performs for a Health Plan.

(c) An individual described in Section 10.3(a) above who fails to comply with the provisions of the plan document relating to the use and disclosure of Protected Health Information shall be subject to disciplinary action under the City's established policies and procedures.

10.4 Breach Notification

(a) The City will notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

(1) the names of the individuals whose PHI was involved in the Breach;

(2) the circumstances surrounding the Breach;

(3) the date of the Breach and the date of its discovery;

(4) the information Breached;

(5) any steps the impacted individuals should take to protect themselves;

(6) the steps the City is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

(7) a contact person who can provide additional information about the Breach.

The City will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

10.5 Security Agreements of the City

As a condition of obtaining e-PHI from the Plan, its Business Associates and Insurers, the City agrees it will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation between the Plan and the City as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

(d) Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

Upon request from the Plan, the City agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the City.

10.6 Certification by City

A Health Plan (or a health insurance issuer with respect to such Health Plan) may disclose Protected Health Information to the City only upon the receipt of a certification by the City that the plan document has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the City agrees to the conditions of disclosure set forth in Section 10.2. A Health Plan shall not disclose and may not permit a health insurance issuer to disclose Protected Health Information to the City as otherwise permitted herein unless the statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice.

10.7 Effective Date

The provisions of this Article 10 shall become effective on April 14, 2003, or on such later date on which the privacy provisions of the administrative simplification rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") become effective with respect to the particular Benefit Plan. In the event that such HIPAA provisions are repealed, the provisions of this Article 10 shall automatically be deleted from the Plan, effective as of the date of statutory repeal, without necessity of further action by the City.

Any reference to a provision of HIPAA or a regulation issued thereunder shall be interpreted to include any successor provisions of such statutes or regulations.

Article 11. Miscellaneous Provisions

11.1 Employment Rights

This Plan is strictly a voluntary undertaking on the part of the Employer and shall not be deemed to constitute a contract between the Employer and any Employee or Participant, or to be considered for, or an inducement to, or a condition of, the employment of any Employee. Nothing contained in this Plan or any modification of the Plan or act done in pursuance hereof shall be construed as giving any person any legal or equitable right against the City, unless specifically provided herein, or as giving any person a right to be retained in the employ of the City. All Participants shall remain subject to assignment, reassignment, promotion, transfer, layoff, reduction, suspension and discharge to the same extent as if this Plan had never been established. No one shall have any right to Plan benefits, except to the extent provided herein.

11.2 Notice of Address

Each person entitled to benefits from the Plan must file with the Plan Administrator, in writing, notice of his or her post office address and each change of post office address. Any communication, statement or notice addressed to such a person at the last reported post office address will be binding upon such person for all purposes of the Plan, and the Employer and/or the Plan Administrator shall not be obliged to search for or ascertain the person's whereabouts.

11.3 Incompetency

Every person receiving or claiming benefits under the Plan shall be conclusively presumed to be mentally competent and of age until the date on which the Plan Administrator receives a written notice, in a form and manner acceptable to the Plan Administrator, that such person is an incompetent, or a minor, for whom a guardian or other person legally vested with the care of the person or estate has been appointed; provided, however, that if the Plan Administrator shall find that any person to whom a benefit is payable under the Plan is unable to care for his or her affairs because of incompetency, or is a minor, any payment due (unless a prior claim therefore shall have been made by a duly appointed legal representative) may be paid to the Spouse, a child, a parent or a brother or sister, or to any person or institution deemed by the Plan Administrator to have incurred expense for such person otherwise entitled to payment. To the extent permitted by law, any such payment so made shall be a complete discharge of liability therefore under the Plan.

In the event a guardian of the estate of any person receiving or claiming benefits under the Plan shall be appointed by a court of competent jurisdiction, benefit payments may be made to such guardian provided that proper proof of appointment and continuing qualification is furnished in a form and manner acceptable to the Plan Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

11.4 No Assignment of Benefits
Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to affect same shall be void. However, a covered person may direct, in writing, that benefits payable to him be paid instead to an institution in which he is or was hospitalized, to a provider of medical services or supplies furnished or to be furnished to him, or to a person or entity that has provided or paid for, or agreed to provide or pay for, a benefit payable under the Plan. Notwithstanding the foregoing, the Plan reserves the right to make payment directly to the covered person and to refuse to honor such direction and assignment. No payment by the Plan pursuant to such direction shall be considered recognition by the Plan of a duty or obligation to pay a provider of medical services or supplies except to the extent the Plan actually chooses to do so.

11.5 Exclusive Rights
No individual shall have a right to benefits under the Plan except as specified herein; in no event shall a right to benefits under the Plan be or become vested.

11.6 Clerical Error
Clerical error by the Employer or Plan Sponsor shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

11.7 Right to Offset Future Payments
In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous payment. This right to offset shall not limit the right of the Plan to recover an erroneous payment in any other manner.

11.8 Right to Recover Payments
Whenever a payment has been made by the Plan with respect to Covered Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from one or more of the following, as the Administrator, in its sole discretion, shall determine: a person to or for or with respect to whom the payments were made, an insurance company, or any other organization or person.

11.9 Lost Payee
Any amount due and payable to a Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due. Such forfeited amounts shall be applied toward Employer contributions to the Plan. However, if a claim is made by the Participant or beneficiary, any such forfeited amount will be reinstated through a special contribution to the Plan by the Employer and become payable in accordance with the terms of the Plan. The Plan

Administrator shall prescribe uniform and nondiscriminatory rules for carrying out this provision.

11.10 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees.

11.11Governing Instruments

This writing, together with the documentation incorporated by reference into it in Appendix A, is the legal instrument governing the Plan. Any conflict or inconsistency between this document and a writing incorporated by reference into it shall be resolved by giving precedence in the following order, first, the documents incorporated by reference in the Appendix A, then, this document.

11.12 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

11.13 Burden of Proof

A Covered Person or beneficiary shall be required as a condition of receiving a benefit under the Plan to prove from time to time and as often as the Administrator determines reasonably necessary, any claimed status, injury or illness. A Covered Person shall be required to submit, from time to time and as often as the Administrator determines reasonably necessary, to an examination, at the expense of the Plan, by a physician selected by it for proof of an injury, illness, and existing or continuing disability. Failure to provide proof reasonably required herein satisfactory to the Administrator may result in disqualification as a Covered Person or beneficiary under the Plan or denial of the claim for a benefit.

11.14 No Guarantee of Tax Consequences

Notwithstanding anything herein to the contrary, the City neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to Article III will be excludable from the Participant's gross income or wages for federal, state or local tax purposes.

11.15 Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

11.16 Legal Remedy
Before pursuing a legal remedy, an individual claiming benefits or seeking redress under the Plan shall first exhaust all claim, review, and appeal procedures available or required under the Plan.

11.17 Notices
No notice or communication in connection with the Plan shall be effective unless duly executed on a form provided or approved by, and filed with, the Administrator. Such notice or communication shall be properly filed if delivered or mailed by certified mail, postage prepaid, return receipt requested, to the Administrator.

11.18 Waiver
No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and such waiver shall operate only as to the specific term, condition, or provision waived.

11.19 Disclaimer
None of the services available under the Plan is warranted by the City; and participating individuals shall look solely to the service provider with respect thereto. The City assumes no obligations other than those set forth in the Plan and shall not be liable for acts of omission or commission on the part of any Insurer, service provider, or other party.

11.20 No Examination or Accounting
Neither this Plan nor any action taken thereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the City.

11.21 Severability
In the event any provision of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan, and it shall be construed and enforced as if such illegal or invalid provision had never been inserted herein.

11.22 Counterparts
This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original. All the counterparts shall constitute but one and the same instrument and may be sufficiently evidenced by any one counterpart.

11.23 Service of Legal Process
The City Attorney is hereby designated agent of the Plan for the purpose of receiving service of summons, subpoena or other legal process.

11.24 Headings of Articles and Sections
The headings of sections and subsections are included solely for convenience of reference. If there is any conflict between such headings and the text of the Plan, the text shall control.

11.25 Applicable Law
Except to the extent superseded or preempted by federal law, the Plan and all rights hereunder shall be governed, construed and administered in accordance with the laws of the State of Arizona.

In Witness Whereof, the City of Chandler has caused its duly authorized officers to execute this Plan on the _____day of _____, 2014.

City of Chandler

By

_____
Signature

_____
Printed Name

_____
Title

Appendix A. Benefit Plans

The following Benefit Plans are hereby incorporated into this Plan.

Additional terms governing these Benefit Plans shall be as set forth in any applicable Administrative Services Agreement or Insurance Policy which the City or the Plan Administrator may enter into for the purposes of providing Covered Persons with benefits under the Plan.

The terms of any applicable Administrative Services Agreement and/or Insurance Policy, as well as any applicable Summary Plan Description are hereby incorporated into this Plan.

Terms and conditions of these Benefit Plans, including all terms herein incorporated, are subject to modification or termination at any time.

Benefit Plans
Medical Plan (for Active Employees), which includes: • Blue Cross Blue Shield of Arizona Red Option • Blue Cross Blue Shield of Arizona Blue Option
Retiree Medical Plan, which includes: • Blue Cross Blue Shield of Arizona Red Plan • Blue Cross Blue Shield of Arizona Blue Plan
Delta Dental PPO Plus Plan
Vision Service Plan
Life Insurance Plan
Long-Term Disability Plan
Short-Term Disability Plan
Employee Assistance Program (EAP)
Accidental Death and Dismemberment Plan
Travel Accident Plan